

Advocacy: time to communicate

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ARTICLE

SUMMARY

This article offers an introduction to advocacy on behalf of people with mental disorders and/or intellectual disabilities. It concentrates mainly on the issues related to independent specialist advocacy, but refers to other forms also. The term is itself contentious, having different meanings in different contexts. Some of these controversies are outlined here. Inevitably, diverse interpretations imply varying practices, and these too are illustrated briefly. Legislation and concordance of expectations are both contributing to a set of standards to which most advocates in the UK and Ireland will adhere. The requirements that such legislation makes of mental healthcare staff working with independent specialist advocates are outlined, and the ethical dimension of mental health advocacy is noted.

DECLARATION OF INTEREST

None.

argued that advocacy also ensures the improving quality of the care system (Wolfensberger 1977: p. 16). This opinion is echoed in the World Health Organization's statement that: 'Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development' (World Health Organization 2003: front cover).

People with intellectual disabilities (also known as learning disabilities in UK health services), physical impairments, mental health disorders, and also children and older people, often find it difficult to make their voices heard when decisions concerning their lives are made. Their reliance on others and concomitant social isolation can leave them vulnerable to exploitation and abuse.

It is in this setting that advocacy within the UK is expanding. Despite the often fragile funding for its provision, varying approaches and consequent lack of coherence, advocacy is persistent. It is firmly embedded in policy, including the Mental Health Act 2007 and Mental Capacity Act 2005 for England and Wales, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the UK's National Standards for the Provision of Children's Advocacy Services (Department of Health 2002). In Ireland, the Citizens Information Act 2007 has mandated the Citizens Information Board to provide advocacy targeted at people with disabilities in general (Ireland Government 2007).

We carried out a range of literature searches in the preparation of this article and found that the available publications are largely illustrative and/or polemical. We have attempted here to distil the main themes and issues arising and to illustrate a model of advocacy in mental healthcare that is accepted by the large majority of practitioners in the field in the UK. Various words are used to identify the individual on whose behalf the advocate is working – service user, client, patient, partner – and we use them interchangeably.

What is advocacy?

In modern English, advocacy is commonly understood to mean speaking, pleading or interceding for someone else. In its report on patient advocacy, the Royal College of Psychiatrists states that 'In relation to people with mental health problems or learning

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This article sketches out some of the core issues of advocacy practice in UK mental healthcare. The potential range of this topic is huge, from individual care to influencing government policy. Advocacy occurs in a number of arenas, including the legal process, but in this article the discussion is limited to the clinical setting. We hope to illustrate some of the key issues of mental health advocacy and to show how those who act as advocates can be supported and helped in their often difficult work. We strongly contend that advocacy benefits the mental health of service users in the longer term, although in the short term it may prove onerous for both advocates and psychiatric staff.

Why advocacy?

The central tenet of advocacy in healthcare is that service users should be enabled to speak up on their own behalf and empowered to take a lead in the decision-making process. The various types of advocacy are held together by the 'matrix' of self-advocacy: speaking up for oneself (Campbell 1991: p. 155).

There are many ways in which advocacy can benefit mental health: it improves the individual's understanding of their situation, enables their views to be heard, ensures that they have the opportunity to be partners in their care and increases their autonomy. Advocacy promotes the rights of those who suffer discrimination because of their age, disability, sexuality, gender or culture. It has been

difficulties, it has the rather different meaning of helping people to be heard, and ensuring that what they say influences the decisions of clinical staff' (Royal College of Psychiatrists 1999: p. 6).

In practice, the word is used to cover a wide range of activities, resulting in obfuscation of the core concerns (World Health Organization 2003: p. 46). This lack of a clear interpretation has delayed attempts to achieve consensus on what is good practice and how it may be evaluated (Henderson 2001: p. 14). Its meaning here is restricted to those activities carried out within a set of principles outlined in Box 1, and carried out by specific individuals employed, or volunteering, for the purpose. This limitation contrasts it with what Wolfensberger (1977) describes as 'cheese advocacy', referring to a commercial that suggests one can take any kind of food and add cheese to it. There is, he argues, a similar tendency to describe any form of verbal support given to the individual as advocacy, irrespective of whether the person has even been consulted.

The word accumulates meanings according to the agenda of the person using it. It can be used to support conflicting ideologies and practice, with little or no reference to the views of the people supposedly being represented (Milner 1986). An example that illustrates Wolfensberger's concerns is when individuals, whether they be staff, friends or family members, acting as advocates promote their own preoccupations (Caras 1998).

Wolfensberger, writing in Canada, believes that merely speaking on behalf of another is not enough. Advocacy, he writes, 'implies a vigor, a vehemence, a commitment, ... a high cost, often in the form of risk', with concomitant 'hostility from others, taunts, being considered foolish or crazy, loss of income, loss of job, loss of health, physical hurt and

violence – perhaps even of death' (Wolfensberger 1977: p. 18).

This belief is expressed only a little less passionately by some British commentators: 'It is not the professional deciding what is best, but the genuine attempt to get into the mind of the patient/client, which is the basis of genuine advocacy' (Brandon 1995: p. 35). Tyne recommends that the advocate must be prepared to be excluded, along with the person who is their protégé. He argues that by 'taking a responsibility in someone else's life, one has to be prepared to suffer the consequences', contrasting this with the professionals who 'have for a long time "taken responsibility" in the lives of disabled people, without of course having to suffer the consequences – just as kings and princes were rarely brought to book' (Tyne 1994: p. 253). Thomas and Bracken echo this opinion, arguing that advocacy 'has a key role to play in mediating the dangers of unchecked medical paternalism in psychiatry' (Thomas 1999).

Such fiery rhetoric can leave psychiatrists troubled. Gamble (1999) worried about the 'destructive ideology-driven power' of some advocacy movements. Tyrer noted that his psychiatric colleagues were suspicious and sometimes overtly hostile of advocacy and patient empowerment (Tyrer 1989). However, he emphasised that clinicians should not form 'defensive bastions' against patient power.

In general mental health practice, however, the experience is usually less charged. Having an advocate attend a patient review can be appropriate and helpful (personal experience, T.H.). The following extract shows good practice in implementing independent mental health advocacy:

As an advocate, I have found it important to build up a good working relationship with ward staff. I do this by meeting with staff at team meetings to tell them about the service and I sometimes do a presentation on advocacy at staff inductions. However, the best way is to keep talking with people individually. I find that students working on the wards have a good understanding of advocacy and are curious to learn about my role. On the other hand, qualified staff respond to me in different ways – some are what I call advocacy friendly and others less so. (Barnes 2007)

Psychiatrists canvassed in the preparation of the College's report on patient advocacy described 'numerous positive experiences' (Graham 1999). They found difficulties only when the advocate lacked sufficient training or independence, or when 'an adversarial situation had been allowed to arise' through inadequate services or poor communication. A more recent study found increasing acceptance of advocates by mental health staff, although the authors note that there is still some way to go (Carver 2005).

BOX 1 The key characteristics of advocacy

- *Empowering* The ideal is to enable individuals to speak for themselves (or if that is not possible, to ensure that their point of view is acknowledged and understood), allowing them to make informed choices
- *Independent* Advocates must not be employed by the organisations making decisions regarding the partner's life. They must be able to express their partner's views without prejudice to themselves.
- *Inclusive* Everyone should be able to access an advocate, irrespective of any aspect of their personal situation, including their ethnicity, culture, gender, sexual preference or age
- *Impartial* Advocates must not judge their partner. They might be the only person who can represent their partner's point of view and they must present it as valid and as the truth for that person
- *Confidential* All information shared between the advocate and their partner is confidential, except where harm is threatened to anyone. Any information given to the advocate will be shared with their partner, in all but exceptional circumstances
- *Free* Advocacy services must be free to the recipient

(Modified from Barnes 2002)

History

The advocacy movement

One of the earliest self-advocacy documents on record is the Petition of the Poor Distracted People in the House of Bedlam in 1620 (Brandon 2000). Over two centuries later, in 1845, Richard Paternoster established the Alleged Lunatic's Friend Society. He recruited John Perceval, who, following 3 years' incarceration, wrote vociferously about his maltreatment. They introduced themes that even now recur: demands for a voice in decisions about care, campaigning for change and alignment with radical politics (Hervey 1986).

In the 20th century, self-advocacy again came to the fore in relation to people with intellectual disabilities in Sweden and the USA in the late 1960s. In the UK, two 'participation' conferences were held in the early 1970s by the Campaign for People with Mental Handicaps. This organisation grew with the development of many local and regional groups throughout the country after the formation of People First in London in 1984 (Atkinson 1999: pp. 9–12).

The citizen advocacy movement, born in the USA in the 1960s, became established in the UK in 1981 with the formation of the Advocacy Alliance, for people with intellectual disability. The Alliance came about through a coalition of five major voluntary agencies (Mind, Mencap, One-to-One, the Spastics Society and the Leonard Cheshire Foundation). Advocacy has spread to other arenas, including old age, mental disorder, deafblindness and hearing impairment. By 1987, 60% of adult training centres for people with intellectual disabilities had some form of self-advocacy group (Brandon 1995: p. 67).

Self-advocacy for people with mental health problems was established in the UK in 1985 through the formation of Survivors Speak Out, influenced by workers in The Netherlands (Barker 1986). In the 1990s, there were over 900 Survivors Speak Out groups operating, although there has been a subsequent decline in numbers (Wallcraft 2003). One of these, the Nottingham Advocacy Group, integrated three components – paid advocacy, patients' councils and a citizens advocacy scheme – into one service. This has been praised as a model system (Mullender 1991: p. 6).

National policy and legislation

The first national strategy for people with intellectual disabilities in the UK was introduced by the Welsh Assembly (Welsh Office 1983). The inclusion of funding for self-advocacy increased the number of self-advocacy groups in the Principality from 2 in 1985 to 58 in 1995 (Whittel 1998).

Valuing People, the government White Paper on services for people with intellectual disabilities in England, placed considerable emphasis on both advocacy and self-advocacy (Department of Health 2001a). Recognising that both were unevenly developed across the country, it committed £1.3 million a year for the next 3 years to correct this. By 2004, there were 43 advocacy organisations funded through the grant (Greig 2004).

The Mental Capacity Act 2005 for England and Wales launched the Independent Mental Capacity Advocate service. Some critics considered that it was implemented hesitantly, and raised concerns about the short-term nature of the associated funding (Gillen 2007). There still appears to be little evidence of evaluation of the service. Informal evidence that we have been given indicates that implementation is patchy and that the independent advocates have in some cases largely endorsed the opinions of clinical staff.

One of the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 is an independent advocacy service for people with mental illness, dementia, intellectual disability and personality disorder (Scottish Government 2005). The Scottish Independent Advocacy Alliance has now published a code of practice, and a set of principles and standards (Scottish Independent Advocacy Alliance 2008a,b). There is no separate advocacy service for people lacking capacity, as in England and Wales.

In Ireland, the 2004 Comhairle (Amendment) Bill delegated to the Citizens Information Board (then known as Comhairle) the responsibility for providing services for all people with disabilities. The Board has promoted a three-stranded strategic approach comprising a personal advocacy service, a programme of support for community and voluntary organisations, and a community visitors programme.

The Mental Health Act 2007 for England and Wales has followed the Scottish lead by instituting the right of detained patients to have access to independent mental health advocates, who 'will help patients understand the way the Mental Health Act applies to them, and what can and cannot be done as a result' (Department of Health 2008b). Unfortunately, the shine has been taken off this by the fact that, although the act took effect from November 2008, the section relating to advocates will not be introduced in England until April 2009, causing some dismay (Shepherd 2008). This delay did not affect Wales, where the service was implemented in November 2008. Many staff in psychiatric services have expressed anxieties regarding patient advocacy, but it is hoped that these will be assuaged by professionalisation of the

advocacy service, with the provision of training and development of national standards for such advocates (Carver 2005).

Advocacy in practice

In discussing the practice of advocacy in mental healthcare, We will consider three areas: the nature of advocacy and its practitioners, the role of healthcare staff, and the diversity of patients and of provision.

The nature of advocacy and its practitioners

The individual and the group advocate

A mental health advocate may be one of a range of individuals: the person themselves (the self-advocate), a friend or family member, someone with specific training in advocacy or a lawyer. Wolfensberger (1977) promoted the concept of the 'citizen advocate', a volunteer who takes on the role as part of their sense of responsibility as a member of society, who would befriend their protégé over months or years. This concept is hotly contested by those who argue for 'peer advocacy', where the supporter has used similar services and can employ this experience to understand the individual better (Brandon 1995: pp. 92–99).

Advocacy can also be carried out by people working together in a group, for example through organisations such as Survivors Speak Out and People First.

The purpose of advocacy

Advocates may act for the individual or for the group. Their aim may perhaps be to improve care, to protect safety or rights, to demand further resources or to influence policy. At the individual clinical level, the client may discuss with the advocate their own care, their participation within this and their ambitions for themselves. They may also need an advocate's support to argue for appropriate financial benefits or housing. At the group level, advocates may work with others to effect changes to local or national services, or to represent client groups in arguing for national policy reform.

The advocate's investment: specialist advocates

Independent mental health advocates Advocacy demands time and dedication, and it is increasingly common for advocates to be paid for their services. A report commissioned by the Department of Health on good practice in advocacy (Barnes 2002) made recommendations for an independent specialist mental health advocacy service in England and Wales. Subsequent changes to mental health legislation in the UK gave patients, particularly those subject

BOX 2 Independent mental health advocacy

Available only to people detained under the Mental Health Act 2007, conditionally discharged restricted patients, individuals subject to guardianship or supervised community treatment

The advocate's role is to:

- help patients to obtain information about and understand:
 - their rights under the Mental Health Act Act
 - the rights that other people have in relation to them under the Act
 - the particular parts of the Act that apply to them
 - any medical treatment that they are receiving or might receive, and the rationale, legal authority and safeguards for it
- help patients to exercise their rights, including representing them and speaking on their behalf if necessary
- support patients to ensure that they can participate in decisions

(Department of Health 2008a)

to conditions of the respective mental health and mental capacity acts, statutory right of access to advocacy, bringing with it the requirement for statutory state funding. The advocates in these situations are usually professional, salaried, trained and subject to specific standards of practice. Working with each client for a limited period of time and for a particular purpose, they do not offer prolonged contact or befriending. They may of course work with the same individual on a number of occasions, but each will be counted as a separate episode. Their role is summarised in Box 2.

The distinctions between different forms of advocacy are more evident in print than in practice. Overlaps occur throughout. Birmingham Citizen Advocacy, for example, employs paid advocates to work on specific issues and recruits volunteers to support individuals over the long term. This is an example how the original citizen advocacy approach has been modified in the light of the development of other provision, in this case specific befriending services.

Independent mental capacity advocates Enabling someone to express their own views is clearly less possible if their mental capacity is diminished. Independent mental capacity advocates (Box 3), because of the specific nature of their clients in most cases, will often have to rely on their own judgement. Where the individual is unable to communicate and has left no evidence of what their preferences would have been, the advocate has to attempt to understand, and ensure that staff have taken into account, what they believe their partner would have wanted. The decision maker has then to make a decision in the 'best interests' of the individual, taking this into account (Lee 2007).

BOX 2 Independent mental capacity advocacy

Provided for anyone over 16 years of age who has no one able to support and represent them, and who lacks capacity (under the Mental Capacity Act 2005) to make a decision about a long-term care move, serious medical treatment, adult protection procedures or a care review

The advocates role is to:

- ascertain, if possible, the individual's hopes, beliefs, and expectations and ensure that these are considered by the decision maker
- represent the person, if instructions are not available, asking appropriate questions and ensuring that their rights are upheld and are central to the decision-making process
- gather, research and evaluate all possible information from all who know the client well and from relevant professionals
- ensure that the person's civil, human and welfare rights are respected
- Audit and, if necessary, challenge the decision-making process

(Speaking Up 2007)

Where there is an advance directive, clearly the advocate has to respect its decisions. A client's doctor may use the Mental Health Act to override those decisions, but the advocate must nevertheless represent them to the best of their ability. Interestingly, there is some evidence that advance crisis plans jointly drawn up by the staff working with the individual reduce the use of the Mental Health Act in admissions (Henderson 2004). An advocate's contribution to this process would be invaluable.

The professionalisation of advocacy

It is now widely recognised that independent trained advocates should work to accepted standards of practice, and receive training and personal support in their role (UK Advocacy Network 2001; Comhairle 2003; Sollé 2006). Good practice guidelines set out core competencies in ethical practice, knowledge, the advocacy process, advocacy skills and attitude (Barnes 2002: pp. 35–36). The last includes tenacity, patience, reliability, desire to problem solve and willingness to learn. The guidelines regard supervision and support to be essential and, as mentioned above, recommend good professional relationships with care staff.

Training and support, of course, require significant financial resources, and there is great concern among the providers of advocacy services about the often temporary and vulnerable nature of the commissioning arrangements in the UK (Atkinson 1999: p. 14; Gillen 2007; Newbigging 2007: p. 110).

The role of healthcare staff in advocacy

For mental healthcare staff two main areas of concern arise. First is the necessity to assist the independent advocate in their work, and second is the advocacy role that they themselves take on.

Staff must understand the nature, and importance, of advocacy. They must be aware of what local services can provide and must enable people in their care to access them (Sollé 2006: p. 15). However, a small survey of 14 clinical staff working in northern England revealed poor understanding of these issues (Lacey 2001).

The practicalities of assisting the advocate

The Mental Health Act and Mental Capacity Act legislation gives staff explicit responsibilities to ensure that a private room is available in which the advocate can interview their partner and that the advocate can interview any person who is concerned with their partner's treatment. With their partner's agreement, the advocate must be allowed access to medical and social services records. Where the partner is unable to express such an opinion, the individual holding the records must agree, where it is appropriate and relevant, that the advocate can access them (Mental Capacity Act 2005).

Staff should inform the advocate in advance about all relevant meetings and ensure that they feel welcomed if they attend. Although advocates may be invited to attend meetings, the spirit of facilitation may be lacking: one survey reported that 'Advocates often have their time wasted attending meetings invariably organised for the convenience of others, or waiting around for a slot in an otherwise very long meeting' (Newbigging 2007: p. 114).

The advocate must be allowed the time and opportunity to carry out their role, including having appropriate access to their partner and to the information relevant to the case. In interviews, adequate time should be allowed for the advocate to rephrase questions for their partner and to encourage that person to speak for themselves. Where the partner has difficulties in making or understanding decisions, it is important that the advocate is respected for their attempts to discern what the individual's wishes might be.

Advocacy enhances an individual's capacity to question, their ability to refuse a course of action and their autonomy.

Ethical dilemmas of independent advocacy

Staff often find it hard to understand and accept the full implications of the principles underlying advocacy. One of the most difficult is the advocate's obligation to remain impartial. A patient may

request objectively unreasonable, and even risky, options, but the advocate is not there to be cajoled into encouraging them to take a different view. An advocate must, whatever their own personal opinions, represent those of their partner. As Thomas & Bracken express it, someone 'steadfastly refusing a course of treatment, supported by an advocate, against the will of the clinical staff is one of the most difficult ethical dilemmas to resolve' (Thomas 1999).

Those responsible for providing care or treatment are inevitably influenced by safety concerns, social expectations and their own value system. It is, of course, always the aim to have a shared vision of how to proceed; but it is not inevitable. The process of understanding an individual's viewpoint entails recognising the powerlessness, loss of self-esteem and resultant frustration of being someone who has had to, or even been forced to, seek help. The sense of criticism, although often not intended, that staff may experience adds further tension. Particularly in these situations the advocate themselves may experience considerable distress (Sollé 2006: p. 27). This should be acknowledged without trying to persuade them to modify their partner's views.

The primacy of the advocacy relationship extends to confidentiality. Except in extraordinary circumstances, an advocate is bound to share with their client any information that they receive about them. This includes any clinical information imparted by staff.

The advocacy role of healthcare staff

Those concerned with the welfare of people with mental health disorders and intellectual disabilities have long engaged in speaking out on their behalf. Some professions include advocacy as part of their remit. Nurses in the UK are enjoined to 'promote the interests of patients and clients' (Nursing and Midwifery Council 2004). Social workers are also deemed to have a 'clear responsibility to act as advocates for their clients' (Bateman 2000). It may be proper to distinguish this advocacy role from any suggestion that staff are in themselves advocates. This distinction may seem to some unnecessarily fine, but it is important to recognise that professionals are always compromised by their powerful influence over their patients' or clients' care. There is always a confusion of loyalties for employees of the system that is providing a service. This is not a criticism of the integrity of clinicians. It is merely a recognition of the difficulties implicit in the situation. Where decisions are being made about treatment, only an independent advocate can truly support the case of the individual under consideration. However, people rarely request

advocates to support them, putting their trust in individual staff and seeking their support in promulgating their views.

Clinicians also perform advocacy roles outside of the clinic. Many have achieved a great deal through promoting their patients' interests. It is important, though, to acknowledge that such advocacy carries with it the temptation to act on behalf of the people that they are working for without attempting to find out their real wishes. It is always best to encourage individuals to make their own case and to assist them in developing the skills to achieve this.

Invited participation in forums run by people using services can both enhance their influence and encourage them to share opinions about what they really hope for. We have found that decision makers in the health services are more likely to listen to an argument when it comes from a number of sources rather than just one. The expression of service user views alongside those of clinicians can enhance managers' abilities to hear what is wanted and their confidence in expediting change.

Diversity of patients and of provision

It is well recognised that traditional mental health systems in the UK are often inappropriate to the needs of people from different cultures. The Mental Health Taskforce report on mental healthcare services for people from Black and minority ethnic (so-called BME) communities reported that they perceive an overemphasis on institutional and coercive care, the prioritising of professional and organisational requirements over the needs and rights of individuals, and institutional racism (Sashidharan 2004).

Mainstream advocacy services have in turn been criticised for not meeting the needs of these communities. It is argued that as these services are inaccessible to service users and carers from these communities, they can assert their rights and express their pain only within specifically 'BME' mental health projects (Rai-Atkins 2002). Rai-Atkins believes that problems arise from the very origin of the current concept of advocacy in the 'White service users' liberation movement' (p. 34), which is not being easily translated into other languages or cultural references. Among African and Caribbean men, confusion over the meaning of advocacy, coupled with mistrust of established mental health services, may prevent them from realising its value and potential benefits (Newbigging 2007). Nevertheless, the definition given by one Black service user appears to fit the mainstream view very well: 'I think advocacy should be about giving someone a voice in a certain situation where they cannot speak for themselves' (Rai-Atkins 2002: p. 34).

Mtetezi: advocacy in context

The African proverb 'Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for life', quoted in a report on mental health *mtetezi* (advocacy in Swahili) for African and Caribbean men, succinctly captures the nature of the core aim of advocacy – to enable individuals to speak for themselves (Newbiggin 2007). This report reinforces calls for community engagement in the provision of services, allowing the community the resources and authority to define its own advocacy needs. Coupled with this is the recommendation for good-quality, culturally sensitive generic services working in collaboration with services specific to the needs of Black and minority ethnic communities.

The language barrier

In an extensive consultation project regarding advocacy standards, service users across England expressed the opinion that there should be cultural, and often linguistic, compatibility between themselves and their advocate. Their views on interpreters were unequivocal: they did not like the extra individual being present, the risks to confidentiality and the possibility of inaccurate interpretation (Sollé 2006: pp. 16–19).

This enters a complex area of advocacy. The distinction between translation, interpretation and advocacy perhaps needs to be spelled out. Translation may be thought of as the direct conversion of words into another language, interpretation as the attempt to render their meaning clear. This clarification may require lengthy dialogue, which to some degree overlaps with advocacy. Clarifying meaning through dialogue may enable an individual to express their ideas more coherently, an intrusion into the advocate's role. However, less well-trained interpreters may still misrepresent what their client is saying.

A further complication arises where language communities are small. Individuals may be known to each other, resulting in natural reticence and also in the potential intrusion of cultural issues that make it difficult for the advocate, interpreter and client to act entirely independently.

The Department of Health's consultation report on independent specialist advocacy services (Barnes 2002: p. 32) emphasises that staff should receive race, gender, sexuality, age, disability and sensory impairment training. It also recommends that advocacy services should increase the diversity of the staff team, and work with volunteers who can provide the appropriate experience and knowledge. Links with other specialist advocacy services are promoted, to give people greater opportunity to choose an appropriate advocate.

Conclusions

Provision of specialist advocacy for mental health service users in the UK is now required by law. Tensions remain, and these affect both advocates and the mental healthcare staff who work with them. At the core is the issue of what the service user – the patient – wishes and hopes for, and what the service is able to deliver. Advocacy can only sharpen this disparity. Clarity about what is wanted and what is available can only improve decision-making, and hence mental health.

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MCQ answers

1	2	3	4	5
a t	a f	a t	a f	a f
b f	b f	b f	b f	b f
c f	c f	c f	c f	c f
d f	d t	d f	d t	d t
e f	e f	e f	e f	e f

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MCQs

1 An advocate should:

- a always tell their partner anything that they have been told (except in very rare circumstances)
- b express their own opinions
- c speak on behalf of their partner wherever possible
- d always be someone who has used mental health services
- e should be persuaded by staff to change their partner's views.

2 When working with independent Mental Health Act or Mental Capacity Act advocates, healthcare staff:

- a should refuse them access to case notes
- b have no obligation to find them a room in which to interview service users

- c should not help them to gain access to service users
- d should identify when a service user might need an advocate and help them to gain access to one
- e need not support the advocate in doing their job.

3 Independent mental health advocacy:

- a has the support of the World Health Organization
- b has no legal basis
- c is needed for all people using mental health, or mental disability services
- d is not a professionally trained service
- e should be provided by people who have explicit political views.

4 Mental healthcare staff:

- a will always find themselves in conflict with advocates

- b have no responsibilities to act as advocates themselves
- c should not support the advocate if that person becomes emotionally distressed
- d are often used by service users as advocates
- e have no conflict of interest if they act as advocates.

5 Advocacy:

- a has one strictly defined meaning
- b is only ever a short-term intervention
- c does not benefit mental health
- d aims to ensure the 'best interests' of the service user are considered when they do not have capacity
- e is easy.